The PSA storm

Questioning cancer screening can be a risky business in America

Many people in the United States think that screening is a panacea, a way of warding off disease and staying healthy—perhaps forever. Those who question this fairytale view, as we recently discovered, are considered traitors, or even murderers.

On 18 December 2001, the *San Francisco Chronicle* published an article in its sports section about Dusty Baker, manager of the Giants, the city's baseball team. Baker had just had surgery for prostate cancer, which was diagnosed after a "routine" blood test for prostate specific antigen (PSA).

A urologist was quoted as saying that PSA tests had made "a world of difference" in fighting prostate cancer because "doctors have been able to catch the tumors early before they have spread." Baker's doctors had chosen surgery over other treatments, said the article, since surgery was "the surest way to prevent any return of the disease."

Thousands of men would have seen this article and it would have left them with an extremely optimistic picture of the benefits of PSA testing and of prostate surgery.

We wrote to the *Chronicle* arguing that the newspaper had failed to reflect the massive controversy surrounding prostate cancer screening. The *Chronicle*'s editorial team knew nothing about the controversy, which is no surprise given the dominance of the US media by the pro-screening lobby.

The editors invited us to write an opinion piece discussing the reasons why men should not be screened. The piece appeared on 18 January 2002, in a section devoted to personal views and debates.

We argued that the PSA test was unreliable, that it often picked up innocuous tumours, and that picking up such tumours harmed men by causing anxiety and by subjecting them to unnecessary cancer treatments with serious side effects.

A programme to screen healthy men, we said, could not be justified since there was no good evidence that it would change the outcome of the disease. The US Preventive Services Taskforce, we told readers, did not recommend screening for prostate cancer.

Within hours of our piece being published, prostate cancer charities, support groups, and urologists around the country had circulated a "Special Alert" by email. This community has huge faith in PSA tests, and it did not care for our opinion. The email, under the header "ATTENTION MEN!!" urged the community to take action.

By the end of the day, our email inboxes were jammed with accusations, abuse, and threats. We were compared to Mengele, and accused of having the future deaths of hundreds of thousands of men on our hands.

Our view, said one letter, was "geriatricide in the making." The president of a prostate cancer charity said he would be asking "supporters and legislators" to look into our "behavior." Many people wished that we ourselves would get prostate cancer. Others tore apart our credentials, arguing that only urologists were qualified to talk about PSA testing.

A member of a prostate cancer email group advised other members to take two actions. First, he said, put "continued pressure on the *San Francisco Chronicle*" to publish material that would "offset the damage" we had done. The *Chronicle* was bombarded with angry phone calls and emails, and says it has never published a more controversial piece.

Second, he said, "Write to their [the authors'] bosses at University of California Davis and the Office of the President. Tell them to fire these imposters. Tell them these folks should be silenced." The chancellor of the University of California and the dean at University of California Davis medical school have received a flood of letters urging that we are disciplined or fired.

By coincidence, in the week after our piece was published, the United States heard the dramatic news that the benefits of mammography were under debate (see p 432). Suddenly Americans were facing some difficult questions about screening.

"The uncomfortable fact is," said the *Chronicle* (3 February 2002), "despite … the incessant drumbeat telling women to get yearly mammograms and men to get their PSA test, screening for breast and prostate cancer is far from perfect and the decisions are not entirely clear-cut."

The paper was unapologetic about publishing our piece. On 4 February, it pondered the backlash against us: "Amid the frustration, the anger and the vitriol, there is no ignoring the controversy." It published an editorial by a urologist arguing the merits of the PSA test, and another by us discussing the risks.

ERIC RISBERG/AP PHOTO

Baseball star Dusty Baker: saved by a PSA test?

Why did we experience this fierce backlash?

One reason is that the PSA advocacy group is passionate in its belief that routine testing is good for men's health. It wishes to believe that screening really does make "a world of difference." We angered this group by challenging its wishful thinking.

We also stepped on the toes of a very wealthy and powerful pro-screening lobby that stands to make money from encouraging men to get tested. Even some of the patient support groups in this lobby have a conflict of interest, since they rely on pharmaceutical company support.

With the widespread belief in America that every man should know his PSA, a belief driven by politics and not evidence, we fear that sceptical voices like ours will always be drowned out.

Gavin Yamey *deputy editor*
Michael Wilkes *editor, Western Journal of Medicine, Oakland, California*

Competing interests: The authors have received a grant from the Centers for Disease Control to devise a teaching tool for primary care physicians on prostate cancer screening.

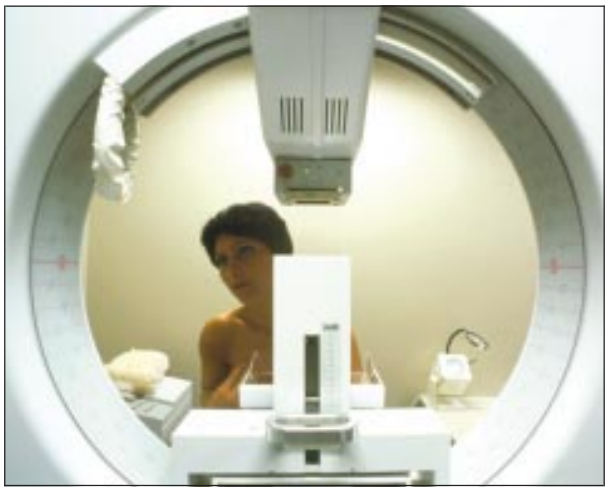
The great American mammography debate

It all started quite quietly. Tucked away on page 16 of the *New York Times* in the fourth week of January was a news item reporting that a committee of cancer experts—the Physician Data Query screening and prevention editorial board (known as the PDQ board)—had found that there was insufficient evidence to show that mammograms prevented breast cancer deaths.

The *New York Times* followed up its news story with a measured editorial, pointing out that a great deal of money was at stake. It predicted that it would not be easy to get an independent review of the benefits of mammography. "Mammography has been so strongly endorsed by the cancer establishment, and has become such a significant source of revenue . . . for many hospitals and doctors, that it may be difficult to excise without overwhelming evidence that it is dangerous. Officials at the National Cancer Institute are said to be reviewing the matter. The institute's new director, Dr Andrew C von Eschenbach, needs to make it a priority."

But at this stage the war was not yet fully under way. Because the committee that had published the findings was highly prestigious—made up of experts from government, leading medical organisations, and academia—it would have to be answered by organisations of comparable status if it was going to be decisively defeated.

So on 31 January, the big guns opened fire. A full page advertisement appeared in the *New York Times* (p A19), signed by 10 medical organisations, including the American Medical Association, the American Academy of Family Physicians, the American Cancer Society, and the American College of Preventive Medicine.



MAURO FERMARIELLO/SPL

Breast screening: now the focus of a bitter media battle

After reviewing the background of the debate, the advertisement said: "We have grave concerns that these public debates have already begun to erode the confidence in mammography that has been built up over the past two decades. While mammography is not a perfect tool, it is effective and has contributed significantly to the declines in breast cancer mortality since 1990."

Other big guns weighed in. The National Cancer Institute, despite the fact that it uses the PDQ board to provide information for its online database, sided with the medical establishment and the status quo. It issued a press release, saying that women should continue to attend for mammograms.

It said:

- Women in their 40s should be screened every one to two years with mammography.
- Women aged 50 and older should be screened every one to two years.
- Women who are at higher than average risk of breast cancer should seek expert medical advice about whether they should begin screening before age 40 and the frequency of the screening.

Dr von Eschenbach concluded: "It is absolutely essential to look beyond the debate over the limitations of current data and to accelerate the development of better screening tools."

The war continued to rage both in the newspapers and on television. On Saturday 2 February, *Weekend Journal* on CBS News featured Lorraine Pace, a breast cancer survivor and mammography activist, and Dr Peter Greenwald, the National Cancer Institute's cancer prevention chief, who said: "The guidelines won't change."

It was left to the *New York Times* to deplore the defensiveness of much of the debate. On 5 February, an editorial entitled "Circling the Mammography Wagons" began: "As the debate over the value of mammography intensifies, it is disappointing that key organizations and individuals in the cancer establishment have mostly chosen to draw their wagons in a defensive circle."

The editorial concluded: "But a serious and open reassessment of the data is crucial." It suggested that either the National Cancer Institute or the National Academy of Sciences would be the most credible organisation for the task.

It would be nice to think that a serious reassessment of the data could be undertaken, but since the mammography business is worth between $3bn (£2.13bn) and $4bn a year and 30 million US women have mammograms every year, the signs do not look hopeful.

Fred Charatan *retired geriatric physician, Florida, USA*

WEBSITE OF THE WEEK

Cancer screening There is no denying that the web internationalises debate. It can also make you a hero or a villain in a web based community that you barely knew existed. Gavin Yamey and Michael Wilkes (p 431) discovered that questioning the wisdom of screening for prostate cancer ensures that your inbox is full of "accusations, abuse, and threats." They raised a storm with their editorial in the *San Francisco Chronicle* (www.sfgate.com/cgi-bin/article.cgi?file=/chronicle/archive/2002/01/18/ED135201.DTL). The *Chronicle* provides a helpful feedback button that carries readers' views instantly to authors. It allows you to email the article to a friend. Great features but dynamite at your fingertips.

There is also a hypothesis that correspondents are far more disinhibited electronically than they are on paper. A formal response came from Peter Caroll, a professor of urology and a proponent of prostate cancer screening (www.sfgate.com/cgi-bin/article.cgi?file=/chronicle/archive/2002/02/04/ED200587.DTL). The debate rages, but the US Preventive Services Taskforce supports the sceptic's view (www.ahcpr.gov/clinic/uspstf/uspsprca.htm).

For PSA read mammography (this page). The *New York Times* invited a deluge of protest with an editorial questioning the value of mammography based on the findings of the Physician Data Query (www.nci.nih.gov/cancer_information/doc_pdq.aspx?version=provider&viewid=b906d0d0-63ac-4d55-ac29-2ae992440adf#6). Thunder and lightning were unleashed but the newspaper held its ground arguing for a reappraisal of the data (www.nytimes.com/2002/02/06/opinion/_06WED2.html). The *New York Times* does not offer an instant feedback button but it does boast a hit list of the most emailed articles. Which is where, incidentally, I found this helpful retelling of the mammography story (www.nytimes.com/2002/02/11/health/11MAMM.html?pagewanted=1).

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PERSONAL VIEW

How should doctors decorate their consulting rooms?

How doctors decorate their consulting rooms can be a matter of style, personal preference, territorial imperatives, or culture. Some doctors believe that patients need to see certain images and motifs there. Take the average heterosexual middle aged clinician. He or she will have pictures of his or her family prominent on the desk, with kiddy drawings scattered around the walls. Doctors approaching retirement may have additional photos of grandchildren.

There is a widespread feeling in the medical profession that patients are reassured by seeing their doctor in a family role—one, it could be said, with which they can identify and which generates trust. Many doctors would recognise that having a family has immeasurably improved their consulting style; but is the consulting room truly the place to put the family on display? I really do not think so.

> Doctors should abstain from having family photos in their consulting rooms

After reflecting on the vulnerability of my patients, I have removed my family photos from my consulting room. Many of my patients' lives have been utterly blighted by long term mental illness and they will never experience the exquisite joy of having children. Often they are poor, working class, isolated, and from a traumatically dysfunctional background; whereas I am a white, middle class, professional, affluent psychiatrist. Surely it is not right to confront them with images of a happy family life, thus accentuating the colossal gaps that exist between us?

It is not merely those with mental health issues who may be painfully touched by happy family images. What about the 10% of couples who are infertile and who often, as a result, experience chronic sorrow? Or those who may have had a miscarriage or have a child with special needs, or, indeed, are attending to seek a termination? What about women who have been physically, emotionally, or sexually abused or young people finding their way in life—are they likely to warm to, trust, or listen to a person flaunting such alienating images and who displays about as much congruence with them as a Martian? How do gay patients feel about such rampant displays of heterosexuality? How do refugee patients who have lost everything feel about such images of ebullient and affluent normality? So many of our patients are beyond the social pale and suffer profoundly for it. The classic consulting room photos must accentuate these feelings.

We doctors have it all—a marvellous vocation and an affluent lifestyle that enables us to give any children we have a head start in life. Is it tenable for us to present patients with such an emotional challenge during a consultation, when they are likely to be feeling emotional anyway? I suggest that they may leave the consulting room more upset than when they entered it, because when someone is vulnerable already, other painful issues tend to come flooding into one's consciousness.

Maybe in reality it is the doctors who need fortifying with supportive family images—for example, to dilute the impact of the heart sink patient or even to keep the patient at a physical distance. It is strangely ironic that doctors who loudly declare that they do not divulge personal details of their lives to patients nevertheless confront them with immensely revealing, evocative images of their families.

Patients do notice family photos in the consulting room, as do their friends and families, if and when they accompany them. I have received many comments about photos, even those hung discreetly. We doctors often forget that patients are as interested in us as we should be in them. A portion of the average patient's attention is focused on assimilating details about their medical practitioner, with motives no more prurient than our own. Practice or hospital leaflets giving details of our qualifications and medical school do not in any real sense empower patients. Patients therefore, quite appropriately, seek other clues to our identity.

I believe strongly that doctors should abstain from having family photos in their consulting rooms. To have them on display is to forget utterly what the purpose of the consultation is—that is, to be patient centred.

It is quite possible to make a consulting room friendly and welcoming without the specifically personal dimension of photos. Colour schemes can be altered to include more pastel shades rather then clinical white. Why have drug company posters with frightening names and bland images when one can frame a poster for a few pounds? Lighting does not have to blaze down from fluorescent tubes when there are modern systems that shine softly at the ceiling, providing a more therapeutic environment for patients to reveal their physical and mental distress. Rugs and carpets can be employed to inject warmth. Interior designers can be consulted.

The ways in which we doctors choose to imprint our personalities on our consulting rooms are many and varied. There must be plenty of scope for a thesis on what is an important aspect of the doctor-patient relationship.

Martin Gaba *staff grade psychiatrist, Luton*

SOUNDINGS

Fire down below

Someone somewhere must have been the first to compare reorganising the NHS with rearranging the deckchairs on the *Titanic*. The joke does not bear analysis—the health service is not about to capsize—but "rearranging the deckchairs" entered the language because it catches the real feeling in the engine room about activities on the bridge.

The only people who go up and down the ladder between the two are doctors. A few of us spend part of the week in London on the medical equivalent of the promenade deck and part of it back home working in the galley.

Or rather, this week, not working. I am writing in January and elective surgery in our hospital has been cancelled, as it was last year and the year before that and the year . . .

Below deck, your reaction is fury. You are the person who saw the patients and shared their pain and anxiety. You are the person who will see them when they are finally admitted. Your fury is only increased by knowing that they will not blame you or anyone else for the failures of the NHS.

Above deck, you are all urbanity. You nibble a custard cream, comment on the second draft of a discussion document, and check your diary for dates for the next meeting.

If yesterday's anger intrudes into your conversation you feel foolish. Your colleagues smile and advise you not to let it get to you. After a while you think they are right.

Your upper deck friends are talented and committed people. They may not feel raw rage when the service breaks down but they do want to improve things. The problem is that the higher people are in the NHS ship, the less is the fire in their belly. And on the bridge are the politicians, cold as ice and ignorant about everything except politics.

It may be mythology but I like to think that the NHS was brought into being by combining Beveridge's cool brain and Bevan's hot blood. According to his biographer, Michael Foot, Aneurin Bevan was "a man of passion and compassion." Those are exactly the qualities missing from the politicians who are steering the ship today.

Those, and knowledge about life below deck.

James Owen Drife *professor of obstetrics and gynaecology, Leeds*